FAMILY INFORMATION UPDATE

State Form 51358 (R2 / 4-06) / BCD 0094
Division of Disability and Rehabilitative Services
Instructions: To be completed annually or as family changes occur.

Name of county

First Steps

☐ **Annual review** (*all sections must be completed*) ☐ **Update** (*complete only those sections that have changed*) *Effective May 01, 2006*

Name of child	Date of birth (*month, day, year*)
Social Security number	Name change of child (*if applicable*)

A. DEMOGRAPHIC INFORMATION

Name of head of household (*person financially responsible*) (*last, first, middle initial*)

Mailing address (*number and street, city, state, and ZIP code*)	Telephone number ( )

B. CHILD DIAGNOSIS AND PHYSICIAN INFORMATION

(Update annually the child's diagnosis and primary care physician. If the diagnosis or physician change throughout the year, please note the change as it occurs. Diagnosis may be confirmed by the physician's signature on the Physician's Health Summary.)

Name of diagnosis	ICD 9 code	☐ Diagnostic verification must be attached

Name of child's primary care physician	Type of physician

C. PUBLIC INSURANCE INFORMATION

(Please check all that apply and list the ID numbers)

☐ Hoosier Healthwise / Medicaid ID number _____ ☐ CSHCS ID number _____

D. INCOME AND FAMILY SIZE VERIFICATION

(Collection of financial information must be completed during a face to face meeting with the family. Income for family members living in the household, must be collected and verified. Family members are defined as the child, the child's parent(s), and the child's siblings with whom the dependent child lives. All natural, adoptive, or half siblings who meet the definition of dependent child must be included in the family group. The income or family size would not include that of a step parent. To document changes in family size throughout the year, please note only those elements that have changed (Example: documentation of a new sibling or the change of income for one member of the family). For annual income verification, please list all family members and income.
List only the change when submitting an update.

NAME	RELATIONSHIP TO CHILD	DOB	NAME	RELATIONSHIP TO CHILD	DOB

	1		2		3	
Name of person receiving income						
Name of employer						
Address of employer						
Wages / fees / commissions / tips / sick benefits	Gross amount	How often	Gross amount	How often	Gross amount	How often
Employer tax ID number for income listed above						
Social Security / SSI (SSI NOT counted for CSHCS)						
Dividend / interest on savings						
Unemployment compensation / strike benefits						
Alimony / child support						
Regular contributions from persons not living in the household						
Other, including: Trustee assistance, farm income, rental income, pensions, trusts, royalties, estates, and military compensation						

Please attach copies of the 3 most recent consecutive pay stubs, other proof of income, or the current 1040, whichever is most appropriate.

I have supplied accurate information and agree with the calculations above:	
Signature of parent / guardian	Date (*month, day, year*)
I have reviewed all documentation and/or agree with the calculations above:	
Signature of service coordinator	Date (*month, day, year*)

DISTRIBUTION: Original - SPOE, Copy - Service Coordinator and family